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30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information submitted by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers, except where there are special level of care facilities approved by the United States department of health and human services. The limits shall be determined by the median in each cost center plus a percentage of the median. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) administration;

(ii) property;

(iii) room and board; and

(iv) health care.

(B) The property cost center limit shall consist of the plant operating costs and an adjustment for the real and personal property fees.

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(C) The base health care cost center limit shall be calculated on the statewide average case mix index determined from the classified resident assessments:

(i) the health care cost center limit for each facility shall be calculated by adjusting the base limit by that facility's average case mix; and

(ii) resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(D) The percentile limits shall be determined from an annual array of the most recent historical costs of each provider in the data base.

(3) To establish a per diem rate for each provider, a factor for incentive and inflation shall be added to the allowable per diem cost.

(4) Resident days in the rate computation.

(A) Each provider which has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(B) The 85 percent minimum occupancy rule shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider unless the provider is allowed to file a projected cost report.

(C) The minimum occupancy rate shall be determined by multiplying the total

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number of licensed beds by 85 percent. In order to participate in the medicaid/medikan program, each nursing facility provider shall obtain proper certification for all licensed beds.

(D) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(5) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(6) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(b) Comparable service rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the medicaid/medikan program.

(2) The agency shall maintain a registry of private pay rates submitted by providers.

(A) Providers shall notify the agency of changes in the private pay rate and the effective date of that change so that the registry can be updated.

(i) Private pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable; and

(ii) providers may send private pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency.

(i) If the private pay rate effective date is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the private pay rate effective date shall be the issued certification date.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables:

(A) A differential for a private room may be included in the average private pay rate when medicaid/medikan residents are placed in a private room at no extra charge and the private room is not medically necessary. In these cases, the private pay rate shall be determined using the weighted average of the private pay rates for residents in both

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private and semi-private rooms. If medicaid residents are not in private rooms or they are being charged extra for the private room, then the private room rate shall not be included in determining an average private pay rate;

(B) Extra charges for ancillaries, routine supplies and other items included in the medicaid/medikan ratemay be included in the average private pay rate.

(C) If a level of care system is used to determine the average private pay rate, the level of care used to compute the private pay rate shall be that which best characterizes the entire medicaid/medikan population in the facility. Additional level of care change information shall be submitted on forms prescribed by the agency. An average private pay rate shall be based on the weighted average of the medicaid/medikan population reflected in the additional information.

(4) The average private pay rate shall be based on what the provider reasonably expects to receive from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents.

(5) The private pay rate for medicare skilled beds shall not be included in the computation of the average private pay rate for nursing facility services.

(6) When providers are notified of the effective date of the medicaid/medikan rate,

the following procedures shall be followed:

(A) If the private pay rate indicated on the agency register is lower, then the medicaid/medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry; and

(B) providers who are held to a lower private pay rate and subsequently notify the agency by certified mail of a different private pay rate, shall have the medicaid/medikan rate adjusted on the later of the first day of the month following the date upon which complete private pay rate documentation is received or the effective date of a new private pay rate.

(c) Rate for new construction or new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the medicaid/medikan program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.The payment rate for the first 12 months of operation shall be based on the rate established from the historical cost data of the previous owner or provider. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to

the new provider's rate.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may occur when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

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(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(f) Out-of-state providers. The rate for out-of-state providers certified to participate in the Kansas medicaid/medikan program shall be the rate approved by the agency. Out-of-state providers shall obtain prior authorization by the agency.

(g) Determination of the rate for nursing facility providers re-entering the medicaid program.

(1) The per diem rate for each provider re-entering the medicaid program shall be determined from:

(A) a projected cost report in those cases where the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in

accordance with this paragraph.

(2) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program.

(h) Approved reserved days as specified in K.A.R. 30-10-21 shall be paid at sixty-seven percent of the medicaid/medikan per diem rate.

(i) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995.)

30-10-19. Rates; effective dates. (a) Effective date of per diem rates for on-going providers filing calendar year cost reports. The effective date of a new rate that is based on information and data in the nursing facility cost report for the calendar year shall be the following July 1st.

(b) Effective date of the per diem rate for a new provider operating on the rate from cost data of the previous provider.

(1) The effective date of the per diem rate for a new provider shall be the date of certification by the department of health and environment.

(2) The rate effective date of the first historical cost report filed in accordance with K.A.R. 30-10-17 shall be the first day of the month following the end of the cost reporting period. Any rates paid after the effective date of the rate based on the first historical cost report shall be adjusted to the new rate from the historical cost report.

(c) Effective date of the per diem rate from a projected cost report.

(1) The effective date of the per diem rate from a projected cost report for a new provider, as set forth in subsections (c), (d), and (g) of K.A.R. 30-10-18, shall be the date of certification by the department of health and environment.

(2) The interim rate determined from the projected cost report filed by the provider shall be established with the fiscal agent by the first day of the third month after the receipt of a complete and workable cost report.

(3) The effective date of the final rate, determined after an audit of the historical

cost report filed for the projected cost report period, shall be the date of certification by the department of health and environment.

(4) The second effective date for a provider filing an historic cost report covering a projected cost report period shall be the first day of the month following the last day of the period covered by the report. This is the date that the inflation factor is applied in determining prospective rates.

(d) Effective August 1, 1995, providers shall receive a new rate based on the case mix adjustment. Providers shall receive new rates quarterly based on changes in the average case mix for the facility from previously submitted assessments.

(e) The effective date of this regulation shall be December 29, 1995 (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995.)

30-10-23a. Non-reimbursable costs. (a) Costs not related to resident care, as set forth in K.A.R. 30-10-1a, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to non-working directors and the salaries of non-working officers;

(2) bad debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, as follows:

(A) Federal income and excess profit taxes, including any interest or penalties paid thereon;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property which is not used in providing covered services;

(E) taxes levied against any patient or resident and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of officers and owners;

(7) the imputed value of services rendered by non-paid workers and volunteers;

(8) utilization review;

(9) costs of social, fraternal, civic, and other organizations which concern themselves with activities unrelated to their members' professional or business activities;

(10) oxygen;

(11) vending machine and related supplies;

(12) board of director costs;

(13) resident personal purchases;

(14) barber and beauty shop expenses;

(15) advertising for patient utilization;

(16) public relations expenses;

(17) penalties, fines, and late charges;

(18) prescription drugs;

(19) dental services;

(20) radiology;

(21) lab work;

(22) items or services provided only to non-medicaid/medikan residents and reimbursed from third party payors;

(23) automobiles and related accessories in excess of $25,000.00 each. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;

(24) provider or related party owned, leased or chartered airplanes and related expenses;

(25) therapeutic beds;

(26) bank overdraft charges or other penalties;

(27) personal expenses not directly related to the provision of long-term resident care in a nursing facility;

(28) management fees paid to a related organization that are not clearly derived from the actual cost of materials, supplies, or services provided directly to an individual nursing facility;

(29) business expenses not directly related to the care of residents in a long-term care facility. This includes business investment activities, stockholder and public relations activities, and farm and ranch operations; and

(30) legal and other costs associated with litigation between a provider and a resident or between a provider and state or federal agencies, unless the litigation is decided in the provider's favor.

(b) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses.

(c) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec.

1; effective May 1, 1985; amended May 1, 1988; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995.)

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30-10-23b. Costs allowed with limitations. (a) The following amortized expenses or costs shall be allowed with limitations:

(1) The provider shall amortize loan acquisition fees and standby fees over the life of the related loan if the loan is related to resident care.

(2) Only the taxes specified below shall be allowed as amortized costs:

(A) Taxes in connection with financing, re-financing, or re-funding operations; and

(B) special assessments on land for capital improvements over the estimated useful life of those improvements.

(3) Any start-up cost of a provider with a newly constructed facility shall be recognized if it is:

(A) Incurred before the opening of the facility and related to developing the ability to care for clients;

(B) amortized over a period of at least 60 months;

(C) consistent with the facility's federal income tax return, and internal and external financial reports, with the exception of (B) above; and

(D) identified in the cost report as a start-up which may include the following:

(i) Administrative and nursing salaries;

(ii) utilities;

(iii) taxes, as identified in (2)(A) and (B);

(iv) insurance;

(v) mortgage interest;

(vi) employee training costs; and

(vii) any other allowable costs incidental to the operation of the facility.

(4) Any cost which can properly be identified as organization expense or can be capitalized as construction expense shall be appropriately classified and excluded from start-up cost.

(5) Organization and other corporate costs, as defined in K.A.R. 30-10-1a, of a provider that is newly organized shall be amortized over a period of at least 60 months beginning with the date of organization.

(A) the costs shall be reasonable and limited to the preparation and filing of documents required by the various governmental entities, the costs of preparing sale or lease contracts, and the associated legal and professional fees;

(B) the costs shall not include expenses of resolving contested issues of title or disputes arising from the performance of contracts or agreements related to the purchase or sale of a property or business.

(b) Membership dues and costs incurred as a result of membership in professional, technical, or business-related organizations shall be allowable. However, similar expenses set forth in paragraph (a)(9) of K.A.R. 30-10-23a shall not be allowable.

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(c) the provider shall include costs associated with services, facilities, and supplies furnished to the nursing facility by related parties, as defined in K.A.R. 30-10-1a, in the allowable cost of the facility at the actual cost to the related party, except that the allowable cost to the nursing facility provider shall not exceed the lower of the actual cost or the market price.

(d) When a provider pays an amount in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost under the medicaid/ medikan program in the absence of a clear justification for the premium.

(e) The net cost of job related training and educational activities shall be an allowable cost. This includes the net cost of "orientation" and "on-the-job training."

(f) Resident-related transportation costs shall include only reasonable costs that are directly related to resident care and substantiated by detailed, contemporaneous expense and mileage records. Transportation costs only remotely related to resident care shall not be allowable. Estimates shall not be acceptable.

(g) Lease payments.

(1) Lease payments shall be reported in accordance with the financial accounting statements of the Financial Accounting Standards Board.

(2) Sale-leaseback transactions shall have the costs limited to the amount which the provider would have included in reimbursable costs had they retained legal title to the

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facilities and equipment. These costs include mortgage interest, taxes, depreciation, insurance and maintenance costs. The lease cost shall not be allowable if it exceeds the ownership costs prior to the sale-leaseback transaction.

(h) The effective date of this regulation shall be December 29, 1995 (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Dec. 29, 1995.)

30-10-24. Compensation of owners, related parties and administrators. (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-1a, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident related expense section of the cost report.

(b) Services related to resident care.

(1) If owners with five percent or more ownership interest or related parties actually perform a necessary function directly contributing to resident care, a reasonable amount shall be allowed for such resident care activity. The reasonable amount allowed shall be the lesser of:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the resident-related services actually performed by owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner or related parties.

(2) The resident-related functions shall be limited to those functions which are

normally performed by non-owner employees common to the industry and for which cost data is available. The job titles for administrative and supervisory duties performed by an owner or related party shall be limited to the work activities included in the schedule of the owner or related party salary limitations.

(3) The salary limit shall be prorated in accordance with subsection (c) of this regulation. The limitation shall not exceed the highest salary limit on the civil-service-based chart.

(4) The owner or related party shall be professionally qualified for those functions performed which require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) The owner or related party shall pay any liabilities established in cash within 75 days after the end of the accounting period.

(c) Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be pro-rated. The time spent on each function within a facility or within all facilities in which they have an ownership or management interest shall be pro-rated separately by function, but shall not exceed 100percent of that person's total work time.

Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

(d) Reporting owner or related party compensation on cost report. The provider shall report owner or related party compensation on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of five percent or more, including employees at the central office of a chain organization, shall be owner compensation. Providers with professionally qualified owner or related party employees performing duties other than those for which they are professionally qualified shall report the cost for such duties in the administrative cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and co-administrator of that facility and to owner compensation reported in the administrative cost center of the cost report. This limitation shall apply to the salaries of the administrator and co-administrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner

compensation line in the administrative cost center and shall be subject to the owner-administrator compensation limitation. The provider shall include all owner-administrator compensation in excess of the limitation in the administrative costs used to compute the incentive factor.

(f) Management consultant fees. Fees for consulting services provided by owners and related parties shall be owner's compensation subject to the owner-administrator compensation limit . The provider shall report fees on the owner compensation line in the administrative cost center if the actual cost of the service is not submitted with the adult care home financial and statistical report:

(1) Related parties as defined in K.A.R. 30-10-1a;

(2) current owners of the provider agreement and operators of the facility;

(3) current owners of the facility in a lessee-lessor relationship;

(4) management consulting firms owned and operated by former business associates of the current owners in this and other states;

(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers and other professional people who have common ownership interests in other facilities, in this or other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to resident care. An allowance shall not be made for costs

related to investigation of investment opportunities, travel, entertainment, goodwill, administrative or managerial activities performed by owners or other related parties that are not directly related to resident care.

(h) The effective date of this regulation shall be December 29, 1995 (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995.)

30-10-25. Real and personal property fee. (a) The agency shall determine a real and personal property fee in lieu of an allowable cost for ownership or lease expense, or both. The real and personal property fee shall equal the sum of the property allowance determined under subsection (b) and the property value factor determined under subsection (c). The fee shall be facility-specific and shall not change as a result of change of ownership or lease by providers on or after July 18, 1984. An inflation factor may be applied to the fee on an annual basis.

(b) (1) The property allowance shall include an appropriate component for:

(A) Rent or lease expense;

(B) interest expense on real estate mortgage;

(C) amortization of leasehold improvements; and

(D) depreciation on buildings and equipment, calculated pursuant to subsection (d).

(2) The property allowance shall be subject to a program maximum. Percentile limitations shall be established, based on an array of the costs on file with the agency as of July 18, 1984.

(c) The property value factor shall be computed as follows.

(1) The agency shall determine the sum of the components under paragraph (b)(1) for each facility, based on costs on file with the agency as of July 18, 1984. These sums shall be placed in an array, and percentile groupings shall be developed from that array.

(2) The agency shall determine the average property allowance for each percentile